There was flexion of the toes on deep irritation and then the quick response on slight irritation to which there seemed some objection. While it is perfectly true in the Babinski sign there is a slow response, in others there is a quick response which is quite as positive as if it were deliberate and slow. Dr. McCarthy thought the great value of the Gordon phenomenon is in the cases where you are in doubt as to whether you are dealing with the Babinski sign or not. That is where he has found Oppenheim's and Gordon's sign to be of value. Where these phenomena are absolute and positive, then he considered them to be in favor of a Babinski reflex.

Dr. Eshner said that it is a common observation that patients suffering from multiple sclerosis often exhibit a certain optimism, cheerfulness and hopefulness even while the symptoms and physical signs are growing progressively worse.

TWO CASES OF ASTASIA-ABASIA

By F. X. Dercum, M.D.

The histories are in abstract as follows:

Case I.—A. M., age 19, unmarried; family history negative; personal history negative save an attack of measles at two years of age, which was followed by weakness of both legs, persisting for six months. Two years ago patient suffered from an attack of typhoid fever which confined her to bed for four weeks. For fifteen weeks following she could not stand upon her feet. Subsequently she began to walk with a staggering, swinging gait which slightly improved. A severe fright caused a sudden recrudescence of the symptoms and also brought on hysterical crises.

Present Condition.—Is well nourished but rather obese. Has a high color. Exposed to the air, the skin over the chest assumes a mottled pink-and-white appearance. Dermography also is marked. Examination discloses markedly impaired station and very ataxic gait. There is no paralysis and no atrophy. Reflexes present no anomalies save that both knee-jerks are plus. The general visceral examination is negative. There are no sensory losses. There are, however, typical areas of painful hyperesthesia under the left breast, and over both groins and over the mid-scapular and lumbar spines and over the sacral and coccygeal regions.

Examination of the eyes reveals no abnormalities save that the fields are slightly contracted and sharply indented for red and that the color fields are at places reversed.

The gait which is the most striking symptom presented by the patient presents the following peculiarities.

The patient cannot rise steadily from the sitting posture. When finally she gets on her feet, she is able to walk, but her gait is slow, labored and absolutely unique. One side of the pelvis is swung forward, and with it the leg. The body lurches forward and after swaying for twenty to thirty seconds, she balances herself on the leg. The body is bent forward and the eyes are fixed to the ground. It seems that in her oscillations she would surely fall. The opposite leg is now brought alongside the first and again the body sways. The feet are planted rather widely apart and as she stands the weight is pivoted on the heels, while the balls of the feet rise and fall alternately from the ground. The oscillations of her trunk, both as she stands and as she attempts to walk strongly resemble the titubation seen in cerebellar disease.

Case II.—M. C., woman, age 28, unmarried. Family history negative save for "nervousness" on her mother's side. Personal history unimportant save that she was delicate as a child. At fifteen years of age, suddenly lost the use of her left arm and left leg. Was for a time unable to walk. She was compelled to remain in bed and also lost her voice. Subsequently complete recovery ensued.

Present trouble began with loss of voice in November, 1906, which persisted until May, 1908. At this time she recovered her voice but became unable to walk because of paralysis of the left leg.

Present Condition.—Examination discloses areas of painful hysterical hyperesthesia over the spine, over the inframammary and over the inguinal regions. No palsies or atrophies or other evidences of organic disease.

Examination of the eyes negative.

Gait.—When asked to walk, patient sways for a few minutes and then puts her right foot forward. When about to bear the weight on the right leg, it flexes at the knee and the patient appears as if she were going to fall on the right side of the body; but with the same ease as she appears to fall she regains her erect position and repeats the same step. She states that she can walk a considerable distance with this awkward gait. Patient states that it is the left leg that is paralyzed but yet curiously it is the right leg which gives way and upon which she falls. She puts the left foot forward quite readily and bears her weight upon it, evidently without the least trouble.

ASSOCIATION AND REENFORCEMENT IN APHASIA

By F. X. Dercum, M.D.

Dr. Dercum briefly presented a patient suffering from pseudo-bulbar palsy and several patients suffering from aphasia. He called attention first to the very close relation existing between the anarthria of pseudo-bulbar palsy and the anarthria in motor aphasia. Secondly to the emotional reaction noted in the case of pseudo-bulbar palsy, namely, a tendency to laugh and a similar tendency to laugh in one of the motor aphasics. He then called attention to the intellectual deficit presented by the aphasics. First the general intellectual deficit as exhibited by the aphasics in their inability to carry out consecutively a series of instructions, this failure depending in part upon weakness of memory, impairment of judgment and especially upon impairment of association. Secondly he pointed out that the special intellectual deficit of the aphasics, namely, the failure of the power to comprehend language, is largely dependent upon a defect of the power of association, that is, the power of combination of the auditory impressions, in such a way as to give rise to the conception of the object named. The impairment in the power of association is often revealed in other ways than by the tests of Marie, as by the inability to recognize the qualities of an object, these qualities being named separately. The qualities may be such as are perceived by the sense of sight or such as are perceived by the sense of touch, but are habitually and intimately associated with articulate sounds, *i. e.*, words. The simplest tests are those made by touch and sight association. In tests so made, it is noted that the percentage of failures on the part of the patient is very great, the man having lost the power of associating the qualities of the object when these are communicated by sound, so as to form a conception of the object. In keeping with this it is noted in proportion as the aphasia is pronounced, adjectives and adjective phrases indicating qualities and prepositions indicating relations of one object to